Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: IRVING COPPELL SURGICAL HOSPITAL 400 W I 635 IRVING TX 75063	MFDR Tracking #: M4-09-B133-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: ZURICH AMERICAN INSURANCE CO Box #: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Appealed, carrier has upheld their original decision."

Amount in Dispute: $1,470.62

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This dispute concerns reimbursement for a minor outpatient procedure on 5/1/2009. The Carrier has reviewed the provider's charges and issued reimbursement in accordance with the current Medical Fee Guidelines in the amount of $4973.64. No additional reimbursement is owed at this time."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
05/01/09	Outpatient Services	$3,205.69 x 200% = $6,411.38 + 12.41 (Fee Schedule) = $6,423.79 - $5,057.78	$1,470.62	$1,366.01
			Total Due:	$1,366.01

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital outpatient services.

This request for medical fee dispute resolution was received by the Division on August 5, 2009.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - W1 – Workers Compensation State Fee Schedule adjustment.
   - 59 – Processed based on multiple or concurrent procedure rules.
   - 97 – Payment is included in the allowance for another service/procedure.
2. Division rule at 28 TAC §134.403(e) states, in pertinent part, that "Regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"

3. Pursuant to Division rule at 28 TAC §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent."
4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services are classified into groups called Ambulatory Payment Classifications (APCs). Services in each APC are clinically similar and require similar resources. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Packaged services are considered integral to the primary paid service and are not separately reimbursed. An OPPS payment status indicator is assigned to each HCPCS code. The status indicator for each HCPCS code is shown in OPPS Addendum B, and a full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year, both of which are publicly available from the Centers for Medicare and Medicaid services.
5. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:
   (1) No documentation was found to support a contractual agreement between the parties to this dispute;
   (2) MAR can be established for these services; and
   (3) Separate reimbursement for implantables was NOT requested by the requestor.
6. In dispute are CPT Codes 64718-RT and 64727-RT billed under Revenue Code 360. According to Medicare, these two CPT codes are considered status "T" codes which are defined as outpatient significant procedures subject to multiple procedure discounting. The highest paying Status "T" APC is paid at 100% and all others are paid at 50%. The APC payment plus the 200% allowable over Medicare for these two codes is $1,209.32 each. The respondent paid $0.00 for CPT Code 64718-RT and paid $917.00 for CPT Code 64727-RT for a total payment of $917.00.
7. In dispute is CPT Code 73070-RTTC billed under Revenue Code 320. According to Medicare, this code is considered a status "X" code. Status "X" codes are defined as ancillary services, paid as APCs rather than from a Fee Schedule. The APC payment plus 200% allowable over Medicare for this code is $88.42. The respondent paid a total of $88.41.
8. In dispute are CPT Codes36415, 85014, and 85018 billed under Revenue Code 300. According to Medicare, these codes are considered status "A" Codes. Status "A" codes are paid under a fee schedule or with a prospectively pre-determined rate. According to 28 TAC Section 134.203(c)(1) the fee schedule amount for CPT Code 36415 is $3.75; the respondent paid $2.72. The fee schedule amount for CPT Code 85014 is $4.33; the respondent paid $6.12. The fee schedule amount for CPT Code 85018 is $4.33; the respondent paid $6.12.
9. The respondent made a total reimbursement of $5,057.78. The total APC reimbursement is $6,423.79.
10. Consequently, reimbursement will be calculated in accordance with Division rule at 28 TAC §134.403(f)(1)(A) as follows:

APC	Outlier Amount	Separate reimbursement for implantables WAS NOT requested under Rule §134.403	APC X 200%	Fee Schedule (CMS x DWC conversion factor)	Less amount paid by Respondent	Additional amount due Requestor
$3,205.69	$0.00	$0.00	$6,411.38	$12.41	$5,057.78	$1,366.01

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code §413.031(c), the Division concludes that the requestor is due additional payment. As a result, the amount ordered is $1,366.01.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.305, §133.307, §134.203, §134.403
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,366.01 plus accrued interest per Division rule at 28 TAC §134.130 and §413.019 (if applicable), due within 30 days of receipt of this order.

DECISION/ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.